

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 003915	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/11/2015
NAME OF PROVIDER OR SUPPLIER BLOOM AT EAGLE CREEK		STREET ADDRESS, CITY, STATE, ZIP CODE 5045 W 52ND ST INDIANAPOLIS, IN 46254		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 000	<p>INITIAL COMMENTS</p> <p>This visit was for a State Residential Licensure Survey.</p> <p>Survey dates: August 10 and 11, 2015</p> <p>Facility number: 003915 Provider number: 003915 AIM number: N/A</p> <p>Census bed type: Residential: 53 Total: 53</p> <p>Census payor type: Medicaid: 43 Other: 10 Total: 53</p> <p>Sample: 8</p> <p>Bloom at Eagle Creek was found to be in compliance with 410 IAC 16.2-5 in regard to the State Residential Licensure Survey.</p>	R 000		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE